DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085032 | A. BUILDING _____ B. WING _____ | C 10/06/2011 |

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| WESTMINSTER VILLAGE HEALTH | 1175 MCKEE ROAD DOVER, DE 19904 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced annual survey and complaint visit was conducted at this facility from September 29, 2011 through October 6, 2011. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was fifty-four (54). The survey sample totaled thirty-three (33) residents. | F 000 | Preparation and/or execution of this provider's plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conditions set forth in the Statement of Deficiencies. | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation it was determined that the facility failed to provide dignity during the dining observations. Finding includes:<br><br>1. During the dining observation in the main dining room on 10/5/11 between 11:55 AM and 12:45 PM, E6 (Certified Nursing Assistant/CNA) was observed assisting R91 and R16 with their lunch. E6 was observed using the clothing protector instead of a napkin to wipe the mouths of R16 and R91.<br><br>2. During breakfast observation of residents in the main dining room on 9/29/11 beginning at | F 241 | This provider's plan of correction is prepared solely because it conveys the sincere message of the governing body as follows:<br>All representative entities of Westminster Village have been, are and will be committed to providing the highest quality of care and services to the elderly in compliance with, or exceeding, all applicable local, state, and/or federal laws, mandates regarding the operation of a long term care facility in Delaware.<br><br>The following plan of correction compromises our allegation of compliance with regulatory requirements. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Miriam J. Monterosa, NHA | | 11/7/11 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 241 | Continued From page 1<br>approximately 8:20 AM, two residents, R91 and R30 were at a table with two other tablemates who were being fed by two Certified Nursing Assistant/CNA, E18 and E19. Approximately 29 minutes later at 8:49 AM, breakfast was delivered to R91 and R30 and CNAs, E19 and E17 began to feed these two remaining residents. | F 241 | F241<br>A. Resident #91 and Resident #16 continue to use the clothing protector and napkins at meals in a manner that promotes their dignity and respect. Residents R91 and R30 are served according to the service model when in the dining room for meal periods.<br>B. A review of residents who use clothing protectors was completed and ongoing education to its proper use is being conducted. Residents in the dining room are served in a timely manner after being seated.<br>C. The staff member identified as E6 was educated regarding proper use of a clothing protector. The Staff Development Coordinator (SDC)/designee will educate CNA's regarding proper usage of clothing protector to ensure resident dignity and respect. The Service Model will be carried as follow by the dining services staff. The dining service staff will take the resident's food order upon seating in the dining room. If a resident needs assistance with a meal nursing staff will assist the resident. The Assistant Director of Dining Services will educate the staff on the above proper dining room service model. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that the facility failed to develop care plans for identified care needs for two (R35 and R17) out of 33 sampled residents. Findings | F 279 | | |

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| F 279 | Continued From page 2<br>include:<br><br>1. Review of R35's record revealed she was to be a resident at the facility while construction was completed on her home and then was to be discharged back to the community with hospice.<br><br>Review of R35's care plan revealed the facility failed to develop a care plan with goals and interventions for R35's community discharge. Review of the information with E7 (Social Worker) on 10/4/11 at 3:00 PM confirmed that the facility failed to develop a care plan addressing R35's potential community discharge.<br><br>2. Cross refer F329.<br>Review of R17's Medication Administration Record from June 2011 through October 2011 revealed that R17 was administered Abilify (an antipsychotic medication) 5 mg. (milligram) on a daily basis for delusions. Review of R17's care plans with E2 (Director of Nursing/DON) on 10/5/11 at approximately 10 AM confirmed that the facility failed to develop a care plan for mood and behavioral issues and use of anti-psychotic medication.<br><br>Findings reviewed with E1 (Administrator), E2, and E3 (Health Center Support Manager) on 10/6/11 at approximately 2:45 PM. | F 279 | D. RN Supervisor/designee will conduct random audits 3x/wk/1month to ensure clothing protectors are used appropriately. Variances will be corrected immediately and results are reported to Quality Assurance Committee. Dining observation audit will occur by dining services manager/Supervisor at breakfast meal period 3 times a week for 30 days. Any variances will be corrected immediately and forwarded to QA. Attachment #1.<br><br>F279<br><br>A. Resident #35's care plan was reviewed and an addendum was completed including the goals of community discharge.<br>B. An audit has been completed by Social Services Director and residents with discharge goals have appropriate care plans specific to individual needs.<br>C. Social Services Director has been educated by D.O.N. on discharge planning of residents from community and requirements thereof. | 12/15/11 |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or | F 280 | | |

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| F 280 | Continued From page 3<br>changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for one (R86) out of 33 residents the facility failed to revise the care plan to reflect the current skin care approaches. Findings include:<br><br>Cross refer F309.<br><br>R86 was dependent on staff for all activities of daily living and had a current physician's order that originated on 7/12/11 for gerisleeves (soft cloth sleeves that fit over arm to protect skin) to bilateral upper extremities (BUE) when out of bed (OOB).<br><br>R86's care plan included under potential for pain related to (r/t) skin tears the approach of sleeves at all times every shift. A care plan for history of | F 280 | D. Social Services Director /designee will review resident care plans 5x/week at morning meeting to ensure inclusion of discharge planning as it occurs. Care plan will also be reviewed quarterly with the resident's MDS completion.<br>Attachment #2<br><br>2.<br>A. Resident #17's care plan was reviewed and updated with identifying behaviors.<br>B. Residents receiving antipsychotic medications have been identified and a comprehensive care plan developed that includes all specific behaviors elicited by the resident.<br>C. The Assistant Director of Nursing (ADON)/Designee will educate professional nursing staff on care planning identified behaviors for those residents receiving antipsychotic medications.<br>D. ADON/designee will audit care plans of resident receiving antipsychotic medication weekly for one month noting any variances which will be corrected immediately and reported to | |

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| F 280 | Continued From page 4<br>skin tears or cuts r/t fragile/paper thin skin with the approach of gerisleeves to BUE. A care plan for actual right tricep blood blister with the approach of Dermasavers to BUE when OOB.<br><br>R86 also had a care plan for bilateral upper extremity edema and a care plan for history of (H/O) multiple skin tear on left hand, right arm, and base of thumb, right elbow that did not address the use of gerisleeves.<br><br>The treatment administration record (TAR) for October 2011 documented the use of gerisleeves at 12 AM, 9 AM and 4 PM daily by the nurse.<br><br>Interviews on 10/6/11 with Director of Nursing, E2 and nurse, E12 revealed that it was their understanding that R86 was to wear gerisleeves at all times unless the arms were too edematous to put them on. They also revealed that gauze was used at time to protect the arms.<br><br>R86's care plan was not updated to reflect the current use of the gerisleeves and the alternate approaches when the resident's arms were too edematous to use the sleeves. | F 280 | the Quality Assurance Committee.<br>Attachment #3.<br><br>F280<br>A. Resident #86's skin care approaches were updated in the care plan to include the current use of Geri sleeves.<br>B. Residents requiring Geri sleeves will be identified and their care plans have been updated to reflect current use.<br>C. Staff Development Coordinator/designee will educate professional staff on updating care plan to reflect the current use of Geri sleeves.<br>D. Staff nurses will audit care plan of residents using Geri sleeves 3x/week/1month and update as necessary. Variances will be corrected immediately and reported to Quality Assurance Committee.<br>Attachment #4 | 12/15/11<br><br>12/15/11 |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | | |

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| F 309 | Continued From page 5<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and interview it was determined that for one (R86) out of 33 sampled residents the facility failed to have consistent measures in place to protect the resident's fragile skin. Findings include:<br><br>R86 was dependent on staff for all activities of daily living and had a current physician's order that originated on 7/12/11 for gerisleeves (soft cloth sleeves that fit over arm to protect skin) to bilateral upper extremities (BUE) when out of bed (OOB).<br><br>R86 's care plan included under potential for pain related to (r/t) skin tears the approach of sleeves at all times every shift. A care plan for history of skin tears or cuts r/t fragile/paper thin skin with the approach of gerisleeves to BUE. A care plan for actual right tricep blood blister with the approach of Dermasavers to BUE when OOB.<br><br>R86 also had a care plan for bilateral upper extremity edema and a care plan for history of (H/O) multiple skin tear on left hand, right arm, and base of thumb, right elbow that did not address the use of gerisleeves.<br><br>Observations of R86 during the survey revealed;<br>-10/5/11 at 2:58 PM resident was in the dayroom. with no gerisleeves on.<br>-10/6/11 8:11 AM and 11:53 AM in bed on back no gerisleeves on.<br><br>The treatment administration record (TAR) for October 2011 documented the use of gerisleeves at 12 AM, 9 AM and 4 PM daily by the | F 309 | F309<br>A. Resident #86's physician orders have been changed to reflect Geri sleeves to be worn when out of bed, remove for edema or discomfort. Care plan updated with appropriate approaches for the fragile skin.<br>B. Residents requiring Geri sleeves have had their care plans updated to reflect current use.<br>C. Staff Development Coordinator/designee will educate professional staff on updating care plan to reflect the current use of Geri sleeves.<br>D. Staff nurses will audit care plan of residents using Geri sleeves 3x/week/1month and update as necessary. Variances will be corrected immediately and reported to Quality Assurance Committee.<br>Attachment #5 | 12/15/11 |

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| F 309 | Continued From page 6<br>nurse.<br><br>An interview on 10/6/11 at 8:15 AM with the Director of Nursing (E2) revealed that R86 was to wear gerisleeves but when he has edema they are too tight to put on. She further stated that Dermasavers were used for awhile but they were not comfortable for the resident and made his arms very hot and sweaty. E2 revealed that they were trying to wrap R86's arms with soft gauze to help protect the skin. Record review revealed this however was not an approach on the care plan or the treatment record.<br><br>An interview on 10/6/11 at 1:20 PM with E12 (nurse) revealed that what was actually being documented on the TAR was the nurse's assessment of edema in the arms to determine if the gerisleeves could be put on by the aides. She further revealed that when the resident's arms are edematous the gerisleeves are too tight and cut in to the top of his arm and the facility has placed an order for larger gerisleeves. E12 also stated that it was her understanding that R86 was to wear the gerisleeves around the clock. It was revealed that the need to use gerisleeves on R86 was communicated to the aides in report by the nurses and was not part of the electronic record system that the aides used for resident care. E12 stated that wrapping R86 's arms with gauze had been attempted but would also get too tight from the edema.<br><br>It was unclear in the plan of care what approaches were being used to protect R86's fragile skin when he was too edematous to use the gerisleeves. | F 309 | | |

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| F 309 | Continued From page 7<br>R86 currently had a documented skin tear to the right forearm with steri strips that originated on 9/28/11 and a skin tear to the left elbow that originated on 9/30/11 as well a multiple bruises to both arms. | F 309 | | |
| F 325 SS=D | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews, it was determined that the facility failed to maintain acceptable parameters of nutritional status, such as monitoring of body weight for one (R44) out of 33 sampled residents. R44 was assessed as moderate risk for nutrition, however, the facility failed to have a system to monitor and analyze the collection of nutritional data (including but not limited to dry weights). Findings include:<br><br>R44 was originally admitted to the facility on 8/7/07 with diagnoses including Alzheimer's disease, type II diabetes mellitus, chronic pain, osteoarthritis, hypertension, and end stage renal disease (ESRD) and was on hemodialysis three | F 325 | F325<br>A. Resident #44 was not affected by the deficient practice.<br>B. Residents receiving dialysis services will be weighed per the facility policy. Dietician will analyze dialysis center data including but not limited to dry and wet weights during her nutritional assessments.<br>C. Staff Development Coordinator/designee will educate nursing staff to adhere to weight policy with dialysis residents.<br>D. Staff Development Coordinator/ designee will audit the weights of residents on dialysis 3x/week/x 1 month. Any variances will be corrected and reported to the Quality Assurance Committee.<br>Attachment #6 | 12/15/11 |

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| F 325 | Continued From page 8<br>times a week.<br><br>Most recent quarterly Minimum Data Set (MDS) assessment dated 7/5/11 documented that R44 was moderately impaired for daily decision making (decisions poor; cues/supervision required) and required set-up only for eating.<br><br>Review of the September 2011 and October 2011 Physician's order Sheet indicated that R44 was on a no added salt diet and to avoid high potassium food.<br><br>Care plan implemented on 8/3/10 titled "Potential for dehydration/fluid imbalance related to ESRD, on dialysis. Potential for nutrition risk R/T therapeutic diet for diagnoses of diabetes mellitus and ESRD. Resident consuming 50% of most meals" included the following approaches:<br>- Monitor/record weight monthly and PRN (as needed), as ordered by the physician. Notify M.D. and family of significant weight change.<br>- Encourage 76% or more food intake with each meal.<br><br>Review of the facility's policy titled "Weight" indicated that resident weights are "4. Taken on a designated scale..." The policy failed to include the method for obtaining and monitoring weight for residents on hemodialysis, such as R44. An interview with the Registered Dietician (E5) at the dialysis facility on 10/6/11 at approximately 9 AM revealed that the standard of practice to monitor changes in weights for those individuals on hemodialysis would be to utilize the post dialysis weight or referred to as "dry weight."<br><br>Review of two, quarterly Nutrition Assessment | F 325 | | |

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| F 325 | Continued From page 9<br>dated 1/6/11 and 4/10/11 completed by E5 (Registered Dietician/RD) assessed R44 as low risk for nutrition and R44's weights were noted as 130# and 126# respectively. An interview with E5 on 10/6/11 at approximately 10 AM revealed that she utilized the weights obtained by the facility staff since R44 was weighed immediately upon her return from dialysis at approximately 4 PM on Mondays, Wednesdays, and Fridays, thus, this weight would be considered a "dry weight" for R44. In addition, E5 related that she did not review the dry weights provided by the dialysis facility since it was obtained on a different scale. Review of the document from the dialysis center dated 1/5/11 noted R44's dry weight of 128.04# compared to the facility's weight of 130#. E5 related that this variance of approximately 2# was not significant, thus, in analyzing changes in weight, E5 reiterated that she does not incorporate the dialysis dry weight.<br><br>An interview with two, certified nursing assistants/CNA, E13 and E 14 on 10/6/11 at approximately 1:30 PM revealed that R44 weights were not being obtained when R44 returned from dialysis at approximately 4 PM, but rather after dinner between 6:30 PM and 8:30 PM.<br><br>Although the facility had post dialysis weights, the facility failed to have a system to analyze this information to monitor changes in weight for R44.<br><br>An interview with E3 (Registered Nurse, Health Center Support Manager) on 10/6/11 at approximately 1:30 PM revealed that the facility should be utilizing the post dialysis weight to monitor R44's changes and not weights obtained at the facility. | F 325 | | |

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| F 325 | Continued From page 10<br><br>Review of an annual Nutrition Assessment dated 7/5/11 completed by a different RD, E4 assessed R44 as a moderate risk for nutrition and the documented weight was 124#. Med Pass 2.0 (nutritional supplement), 4 ounces twice a day was ordered and administered to R44 through 8/4/11. On 8/5/11, this nutritional supplement was increased to three times a day and on 8/26/11, the supplement was discontinued, however, record review lacked the reason for the discontinuation. Review of facility weights between 8/26/11 through 10/5/11 fluctuated between high of 122.50# (on 9/5/11) and low of 118.10# (on 10/5/11). An interview with E4 on 10/7/11 at approximately 11 AM revealed that she incorporated the dry weights obtained from the dialysis center as well as the weights obtained at the facility. E4 relayed that in response to the surveyor's inquiries, the facility will initiate utilizing the post dialysis dry weights to monitor and analyze changes in weights for residents on dialysis such as R44.<br><br>Findings reviewed with E1 (Administrator), E2 (Director of Nursing), and E3 on 10/6/11 at approximately 2:45 PM. | F 325 | F329<br>A. Resident #17's medication administration record (MAR) including the "Psychoactive Drug Monthly Record" was reviewed. The resident's targeted behavior is now being monitored by professional staff on the monthly flow sheet.<br>B. Residents receiving antipsychotic medication have targeted behavioral symptom included in the Monthly Flow Record and the resident's care plan.<br>C. ADON/designee will educate professional nursing staff on monitoring of targeted behavioral symptoms on the Monthly Flow record and the resident's care plan.<br>D. ADON/designee will complete an audit 3x/week/1 month for targeted behaviors and any variances will be corrected immediately and reported to the Quality Assurance Committee. Attachment #7 | 12/15/11 |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any | F 329 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 329 | Continued From page 11<br>combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for one (R17) out of 33 residents sampled, the facility failed to ensure that the resident's drug regimen was free from unnecessary drugs and was adequately monitored. Findings include:<br><br>The facility's policy entitled, "Behavioral Management" indicated that resident's behavior will be monitored on the Behavior/Intervention Monthly Flow Record or the "Psychoactive Drug Monthly Flow Record."<br><br>Review of R17's Medication Administration Record from June 2011 through October 2011 revealed that R17 was administered Abilify (an antipsychotic mediation) 5 mg. (milligram) on a daily basis. Review of the "Psychoactive Drug | F 329 | | |

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| F 329 | Continued From page 12<br>Monthly Flow Record" (the record utilized by the licensed nursing staff to monitor behavior symptoms including the target behavior, number of episodes, non-pharmacological and pharmacological interventions, the outcome of the interventions, and presence of any side effects from the pharmacological interventions). for this same period of time failed to include R17's delusional behavior symptom.<br><br>Interview with E2 (Director of Nursing/DON) on 10/5/11 at approximately 10 AM confirmed that the facility failed to adequately monitor the use of the above medication by R17.<br><br>Findings reviewed with E1 (Administrator), E2, and E3 (Health Center Support Manager) on 10/6/11 at approximately 2:45 PM. | F 329 | | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations of the interior of microwave oven in the kitchen on 9/29/11, it was determined that the facility failed to keep food preparation equipment clean. Findings include: | F 371 | F371<br><br>A. Microwave was replaced on 10/5/2011<br><br>B. Microwave will be cleaned on a routine program<br><br>C. Microwave will be placed on a daily cleaning log and cook shift check out log.<br><br>D. Daily log and cook shift check out log will be monitored on the DS MOD log weekly.<br><br>Attachment #8 | 12/15/11 |

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| F 371 | Continued From page 13<br><br>The interior surfaces of the microwave oven located next to the convection oven were observed to have spatters and debris. This unit was replaced with a new microwave oven by 10/05/11. | F 371 | F428<br><br>A. Resident #17's medication administration record (MAR) including the "Psychoactive Drug Monthly Record" was reviewed. The resident's targeted behavior is now being monitored by professional staff on the monthly flow sheet.<br>B. Residents receiving antipsychotic and the targeted behavior symptom are included in the Monthly Flow Record and the resident's care plan.<br>C. ADON/designee will educate professional nursing staff on monitoring of targeted behavioral symptoms on the Monthly Flow record and the resident's care plan.<br>D. ADON/designee will complete an audit 3x/week/1 month for targeted behaviors and any variances will be corrected immediately and reported to the Quality Assurance Committee. Attachment #7 | 12/15/11 |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon record review and interview, it was determined that the monthly Medication Regimen Review (MRR) failed to identify the lack of adequate monitoring for one (R17) out of 33 sampled residents. Findings include:<br><br>Cross refer F329.<br><br>Review of R17's MRR for the months of June, July, August, and September 2011 lacked evidence that the licensed pharmacist identified that the use of the antipsychotic medication, Abilify was being adequately monitored.<br><br>An interview with E15 (licensed pharmacist) who | F 428 | | |

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| F 428 | Continued From page 14<br>conducted the MRR on 10/5/11 at 11 AM revealed that the facility utilized the "Psychoactive Drug Monthly Flow Record" to monitor the use of antipsychotic medication such as Abilify. In addition, E15 related that he also interviews staff and reviews facility records to gather information. E15 was informed by the surveyor that the targeted behavior of delusions which Abilify was prescribed was not being monitored on the above flow sheet and addition, there was no care plan for the targeted behavior symptoms.<br><br>Findings reviewed with E1 (Administrator), E2 (Director of Nursing), and E3 (Health Center Support Manager) on 10/6/11 at approximately 2:45 PM. | F 428 | F431<br><br>A. This deficiency did not result in any adverse effects to the residents. Central Cart: expired Lantus insulin was discarded immediately. West Cart: expired EpiPen and Heparin were discarded immediately. Refrigerator: expired Promethegan suppository discarded immediately. Med Room: expired sterile water, Heparin syringe, Potassium Chloride, and Dextrose 5 % discarded immediately.<br>B. No residents were identified or affected.<br>C. Staff Development Coordinator/designee will educate professional nursing staff to discard expired medications.<br>D. RN Supervisors/designee will conduct random audits of medication carts, refrigerator in med room and cabinets in med room 3x/week/4 weeks. Attachment #9 | 12/15/11 |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature | F 431 | | |

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| F 431 | Continued From page 15<br>controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to ensure that the drugs and biologicals that were stored in the medication room and medication carts were not expired. Findings include:<br><br>On 10/5/11 at 2:00 PM observations were made of the medications located in the medication carts and in the medication room revealed the following:<br><br>-Central cart observed with E12 (LPN) revealed:<br>Lantus expired 9/3/11<br><br>-West Cart observation with E9 (LPN) revealed:<br>Epi pen expired 2/12/11<br>Heparin expired 8/11<br><br>-Refrigerator in medication room observed with E8 (RN):<br>Promethegan rectal suppository one box expired | F 431 | | |

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| F 431 | Continued From page 16<br>4/29/11<br>Promethegan rectal suppository 25 mg. (milligram) one box expired 4/4/11<br><br>-Medication room observed with E8 (RN) revealed:<br>50 milliter bottle of sterile water expired 9/1/11<br>Heparin 12 ml. syringe expired 8/11 11<br>potassium chloride 1000 ml. expired 7/11<br>Dextrose 5% 100 ml. bag expired 3/11<br><br>Review of the observation with E8 (RN) 10/5/11 at 2:45 PM confirmed the above findings. | F 431 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a | F 441 | | |

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| F 441 | Continued From page 17<br>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of the facility's policy and procedures, it was determined that the facility failed to follow their infection control process for proper handwashing and cleaning the glucometer after use and between residents. Findings include:<br><br>The facility's policy and procedure for handwashing stated that hand washing should be done after the use of gloves and after washing their hands they must turn off spigot using a dry paper towel.<br><br>1. During the medication observation on 10/5/11 at approximately 9:45 AM E9 (LPN) was observed washing her hands after removing her gloves from administering an insulin injection. E9 used her clean hands to turn off the water spigot instead of using a dry paper towel. Observation information was reviewed with E9 immediately after it occurred. | F 441 | F441<br>1.<br>A. No residents were affected by the deficient practice. E9 was educated on proper hand washing technique.<br>B. There were no residents affected by the deficient practice.<br>C. Staff Development Coordinator/designee will observe and educate staff on hand washing procedure.<br>D. Staff Development Coordinator/designee will perform random audits of 12 employees per week for one month. Variances will be immediately corrected and reported to the Quality Assurance Committee. Attachment #10 | |

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| F 441 | Continued From page 18<br><br>The facility's policy and procedure for instrument cleaning revealed that the glucometers that are used for multiple residents should be cleaned between resident uses.<br><br>2. On 9/29/11 at 9:40 AM during a medication pass E10 (LPN) was observed performing a finger stick on a resident using a glucometer. The nurse did not clean the glucometer before or after its use. The glucometer was placed back on the medication cart for resident use. E10 stated that there is one glucometer per medication cart for residents use.<br><br>3. An observation on 9/29/11 at 11:26 AM revealed nurse E12 did a finger stick blood sugar on a resident with a glucometer. The glucometer was not cleaned before or after resident use. The nurse put the glucometer back in the medication cart.<br><br>The above observations were reviewed with the E2 DON and E11 Staff Educator on 10/6/11 at approximately 11:45 AM. | F 441 | 2.<br>A. No residents were affected by the deficient practice.<br>B. There were no residents affected by the deficient practice.<br>C. Staff Development Coordinator/designee will observe and educate staff on appropriate glucometer before and after use and between residents.<br>D. ADON/designee will conduct random audits of 8 professional staff members per week for one month. Variances will be immediately corrected and reported to the Quality Assurance Committee.<br>Attachment #11 | 12/15/11 |

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT



**NAME OF FACILITY:** Westminster Village Health Center

**DATE SURVEY COMPLETED:** October 6, 2011

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---|---|---|
| | An unannounced annual survey and complaint visit was conducted at this facility from September 29, 2011 through October 6, 2011. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was fifty-four (54). The survey sample totaled thirty-three (33) residents | 3201.1.2<br><br>Cross refer to the CMS – 2567-L Plan of Correction submitted on 11/07/2011 for the annual survey ending 10/06/2011 on F241, F279, F280, F309, F325, F329, F371, F428, F431, and F441. |
| **3201** | **Regulation for Skilled and Intermediate Nursing Facilities** | |
| **3201.1.0** | **Scope** | |
| **3201.1.2** | **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross refer to CMS 2567-L survey report date completed 10/6/11, F241, F279, F280, F309, F325, F329, F371, F428, F431, and F441. | |